



STYSA

INDIVIDUAL MEMBERSHIP FORM

fees: \$80 for U-10

\$90 for U-11 and U-12

\$100 for U-13 and above

Fees Paid

Mail to:
 Leander Youth Soccer
 PO Box 918
 Leander TX 78646

Youth Division of the United
 States Soccer Federation (USSF)
 Internationale de Football
 Association (FIFA)

Team
Code☐

Assn.

☐

Club

☐

Level

☐

Sex

☐

Age

☐

Team No.

☐

Requested team or coach:

e-mail address:

Use Birth
Certificate
Names
Only

Mailing Address Last First Initial Nickname

() Home Phone () Daytime Phone for Adults

Date of Birth Month Day Year Verified By NYCC TEAM ☐ Male ☐ Female ☐ Player ☐ Coach ☐ Asst. Coach ☐ Other ☐ Coach's License Level

Father's Name Occupation Bus. Phone

Mother's Name Occupation Bus. Phone

List any medical problem or prohibition player has

Person to notify in emergency Telephone

Doctor to notify in emergency Telephone

Number prior seasons played Last Team Last League Date of Last Season 19

Height Weight School Grade

UNIFORM SIZE
 YOUTH ADULT Other Children
 SHIRTS: XS S M L XL XS S M L XL From Family
 SHORTS: XS S M L XL XS S M L XL Presently
 SOCKS: XS S M L XL XS S M L XL In League

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the STYSA, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration by the USYSA, accepting the registrant for its soccer programs and activities (the "Programs"). I hereby release, discharge and/or otherwise indemnify the USYSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

Name Parent/Legal Guardian (please print)

Signature

CONSENT FOR MEDICAL TREATMENT (MINOR)

As the parent or legal guardian of the above-named player, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signature of Parent or Guardian

Address

City State Zip

Phone Home Bus.

PARENTAL SUPPORT

We ask for active participation of all parents in our program.

Check area(s) in which you would be willing to help.

- ☐ Coach ☐ Committee
☐ Asst. Coach ☐ Referee
☐ Team Manager ☐ Fund Raising
☐ Team Parent ☐ Clerical
☐ Special Projects ☐ Reporter
☐ Field Preparation ☐ Newsletter
☐ Board Member ☐ Concessions
☐ Publicity ☐ Donor

Other

OFFICIAL USE ONLY

Picture Received Yes No

Registration Fees: Birthdate Verified Yes No

Player Fee \$ Received By

Coach's Fee \$

Other \$ Date

TOTAL \$

Cash \$

Check No. \$